Approach to Assessing the Impact of the Assignment of Benefits Law

Maryland Health Care Commission

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Under the new law, we have responsibilities, beyond simply holding up a sign

AOB debate was driven by emotion on all sides.

MHCC's Specific Responsibilities Under Section 3

- The Maryland Health Care Commission, in consultation with the Maryland Insurance Administration and the Office of the Attorney General, shall study…
  1. the impact of enacting a cap on balance billing for nonpreferred, on–call physicians *and hospital–based physicians;*
  2. the impact on consumers of prohibiting health insurance carriers from refusing to accept a valid assignment of benefits; and
  3. the impact of requiring direct reimbursement of nonparticipating providers by health insurance carriers on a health insurance carrier's ability to maintain an adequate network.

- MHCC must establish baseline parameters for study by January 1, 2011

- MHCC must submit an interim report to the General Assembly by July 1, 2012.

- MHCC must submit a final report to the General Assembly by October 1, 2014.

Data Sources

- Maryland Board of Physicians Licensure files screened to include only active practice physicians. Inclusion criteria:
  - Reported practice location in Maryland
  - Non-Federal physician
  - Reported practicing more than 5 hours of patient care

- Network participation files submitted by plans to MBP
- Medical Care Data Base (MCDB)
  - Screen for services provided under a fully insured contract.

    Will state be pre-empted from applying AOB rule to ERISA and other self-insured plans, including federal employees?
  - Screen for services from a Maryland place of service.

- Other State All Payer Claims Data Sets that can be used for comparison purposes.

The impact of a cap on balance billing for Non-par *on–call physicians and hospital–based physicians*

Starting assumptions

- Provider's willingness to participate in a network = f(carrier's market share, reimbursement rates, and business rules).
- Under current law, decisions to participate are made on a carrier-by-carrier or network-by-network basis.
- For some carriers, the cap will be 140 percent of in-network rate and for others it will be billed charges.

Possible measures monitored over time

- Percent of physicians that report participating in carrier networks overall and by specialty – MBP/MHCC physician survey
- Percent of physician payments that are classified as OON in total and by specialty – MCDB.
- Average payment levels for a given service by physician characteristics – MCDB
- Percent total private payer payments that are paid OON – MCDB

The impact on consumers of requiring carriers to accept a valid assignment of benefits

Starting assumptions

- Under current law, patients have a preference for participating providers when factors such as quality are equivalent (in hospital and community settings).
- Under the new law, patients will be indifferent to network status if provider accepts assignment.
- The MIA and the AG have extensive data on the number of complaints from consumers on large balance bills.

Possible measures monitored over time

- Share of patients with OON payments overall and by various severity levels – MCDB
- Average OON patient expense as a percent of average total patient overall and by disease levels – MCDB.
- Ability to access care in network care – CAPHS PPO/HMO survey

The Impact of AOB on a Carrier's Ability to Maintain an Adequate Network

Starting Assumptions

- Carriers' ability to maintain an adequate network= f(market share, reimbursement rates, and business rules).
- For some carriers the new AOB cap will be 140 percent of in-network payment and for others it will be "nearly" billed charges.
- CareFirst, UHC, Aetna, CIGNA, Coventry will maintain their own networks.
- Smaller carriers (Trustmark, MEGA, Unicare and Guardian) will use independent networks – PCHS/Multiplan, FirstHealth.
- Kaiser will use PCHS/Multiplan for PPO products.

Possible measures monitored over time

- Share of services paid out-of-network – as reported in the MCDB
- Number of physicians participating in a payer's network as reported to MBP.
- Changes in allowed charges for a particular service – MCDB
- Range in OON payment across payers – new law creates an imbalance in OON payment levels – MCDB

On balance, the benefits and costs associated with the direct reimbursement of nonparticipating providers by health insurance carriers under AOB

Net the costs and benefits of the AOB on the system overall

- Stakeholder-by- stakeholder assessments are based on indicators that can be measured.

- The overall conclusion could be more subjective – possible composite measures could be rate of increase in overall provider spending after controlling factors that are known to drive this spending, i.e., medical inflation, medical technology, and population growth.

Some personal thoughts: the AOB law seems oddly out of step with health care reform

- The AOB law could continue and exaggerates old inequalities among physicians.
  - Many factors influence specialty selection, the adage in medical school that "White follows green" meaning medical students select higher reimbursed specialties.
  - Shortages are most critical in primary care.
- Questionable whether the goals of the bill have been met…
  - Agree on compromise premium payment for providers that must treat in a hospital, but do not participate.
  - Protect patient from extreme payments when they have no choice.

Consider reform signals …

- "Business As Usual" is over
  - expand access
  - make the system sustainable
- Changing obsolete business models
  - End risk selection → helping all find value
  - FFS pay for volume -> pay for value

With Insurance Comes a New Need: More Primary-Care Doctors, March 26, 2010

The New York Times

Health Overhaul May Raise Demand for Primary Care, March 30, 2010

THE WALL STREET JOURNAL.

Present Value Of Career Wealth In Various Professions And Levels Of Educational Attainment, To Age 65, In The Base-Case Analysis

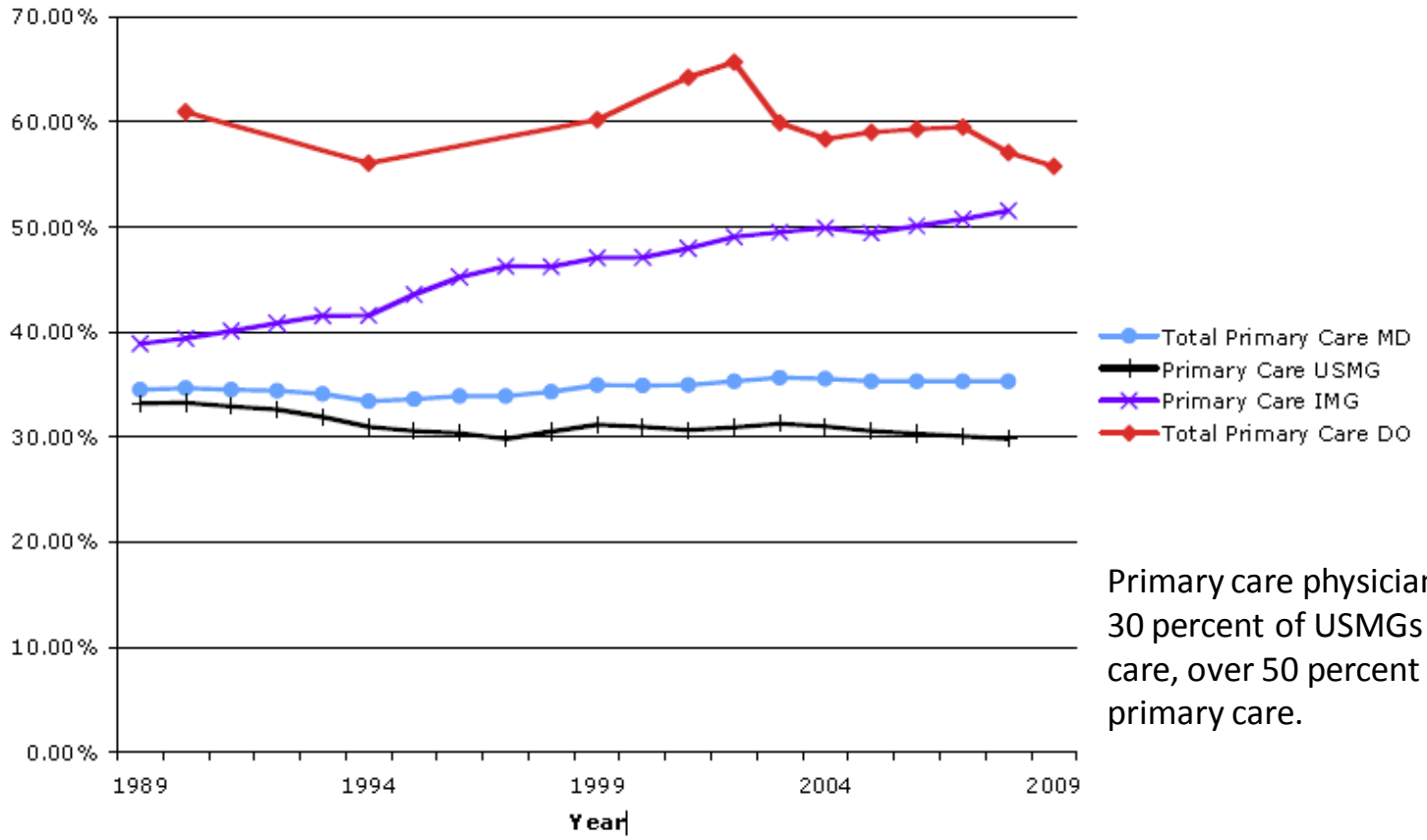
	Comparison of present value of career wealth[a]				
	Cardiologist	Primary care physician	MBA graduate	Physician assistant	College graduate
Base case model present value of wealth	$5,171,407	$2,475,838	$1,725,171	$846,735	$340,628
VALUE COMPARED TO					
Cardiologist	1.0				
Primary care physician	2.1	1.0			
MBA graduate	3.0	1.4	1.0		
Physician assistant	6.1	2.9	2.0	1.0	
College graduate	15.2	7.3	5.1	2.5	1.0

SOURCE Authors' calculations. **NOTE** MBA is master of business administration. [a]Values are expressed as multiples of the comparison group, unless otherwise indicated.

Source: Health Aff (Millwood). 2010 May;29(5):933-40. **Can we close the income and wealth gap between specialists and primary care physicians?** Vaughn BT, DeVrieze SR, Reed SD, Schulman KA.

Make-up of Primary Care Practices – IMGs and Osteopaths Sustain Primary Care

Physicians in Primary Care as Percentage of Total Active, Non-Resident MDs or DOs, 1989-2009

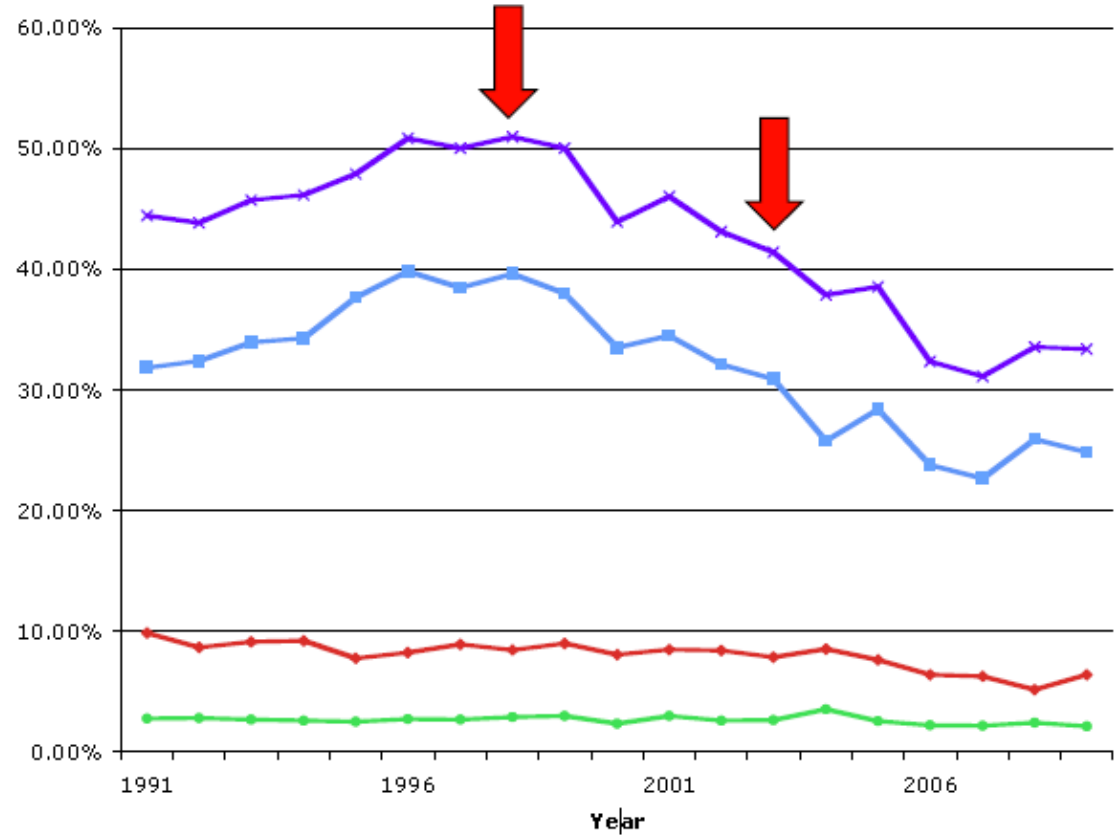


Primary care physician work force, 30 percent of USMGs in primary care, over 50 percent of IMGs in primary care.

Source: AMA Physician Characteristics and Distribution in the US 1990-2010; AOA Osteopathic Medical Profession Report 2005; AOA Annual Report 1990, 1999, 2001-2003

Source: AAMC 2010 Physician Workforce Conference: "Trends in Specialty Mix Among Physicians and Non-Physician Clinicians, 1980-2009" Joseph R. Rojas,

Specialty Distribution of PAs as Percentage of Total Respondents to AAPA Census, 1991-2009



Source: AAPA Database

Adding PAs to primary care physician practices may not be an achievable goal due to trends in specialization among PAs.

PAs, like physicians are specializing, driven by income differentials and ability of large single specialty practice to employ PAs.

Source: AAMC 2010 Physician Workforce Conference: "Trends in Specialty Mix Among Physicians and Non-Physician Clinicians, 1980-2009" Joseph R. Rojas,